

Patient Information				Prescriber Information	
Patient Name:		DOB:		Prescriber's Name:	
Address:				NPI#:	
City:	State:	Zip:		DEA#:	License#:
Phone:		Alternate Phone:		SSN:	
Height:	Weight:	Allergies:		Phone:	Fax:
Emergency Contact:		Phone:		Contact Person:	
Is the patient pregnant, planning a pregnancy or nursing:				Yes	No
				Does the patient need interpreter services:	
				Yes	No

Documentation (Required)		
Insurance Card (front and back)	Current Medications	History/Progress Notes

Specific Labs Needed (note: send ALL labs, must include specific labs listed here)

Other: _____

Client Assessment *(Please fax recent clinical notes, labs and tests to expedite the Prior Authorization Process)*

ICD-9 Codes: _____ Description: _____

ICD-10 Codes: _____ Description: _____

DATA Collection:

Results of hemodynamic monitoring:	Cardiac Index	Pulmonary capillary wedge pressure	Date
Before inotrope infusion	_____	_____	_____
On inotrope infusion	_____	_____	_____

Cardiac drugs provided immediately (digoxin, diuretics, vasodilators) prior to inotrope infusion (include drug, dose, and frequency):

Does this represent maximum tolerated doses of these? Yes No

Breathing status (check one in each column)	Prior to inotrope infusion	At time of discharge
No dyspnea on exertion		
Dyspnea on moderate exertion		
Dyspnea on mild exertion		
Dyspnea at rest		

If continuous infusion is prescribed, have attempts to discontinue inotrope infusion in the hospital failed? Yes No

Additional information: _____

If intermittent infusion is prescribed, have there been repeated hospitalizations for heart failure during which parenteral inotropes were required?

Yes No Additional information: _____

Is the patient capable of going to the physician for outpatient evaluation? Yes No

Is routine electrocardiographic monitoring required in the home? Yes No

Has the patient been stabilized on the prescribed inotrope dose for 24 hours? Yes No

Patient Name: _____

Medication Orders

The maintenance dose will be established and patient stabilized on maintenance dose before first home infusion. Titration of the maintenance dose should not be done in home setting. Safe doses of the drugs should fall within ranges noted below. Any doses falling outside of these ranges should be double checked with a MedicoRX Specialty Pharmacist.

Dobutamine: 2.5-10 mcg/kg/min

Milrinone: 0.375-0.75 mcg/kg/min

Ordered Medication: _____ Dose _____ mcg/kg/min

Clinical rationale for the prescription outside the above dosing ranges _____ or N/A _____

_____ or N/A _____

Dosing weight: _____ kg

Continuous _____ Intermittent _____ Frequency _____ Duration: _____

Pharmacy to dispense 1 pump plus 1 spare pump for emergency.

Dose adjustment: Pharmacy to contact the prescriber every _____ week(s).

Dosing will be adjusted under the direction of a physician based upon the patient's response.

IV access (check one) PICC _____ Midline _____ Other _____ # of lumens _____

Lab: CBC _____ CMP _____ Other _____ Lab frequency: Weekly _____ Other _____

Flush orders/Instruction: _____

(Do not use Heparin flush with Dobutamine: Incompatible)

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature

Date